STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 01 B. WING	08/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT ROAD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 08/02/11 Facility Number: 000070 Provider Number: 155149 AIM Number: 100266190 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Harcourt Terrace Nursing and Rehabilitation was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility with a partial basement was determined to be of Type III (211) construction and fully sprinklered. The facility has a fire alarm system with smoke detection on all levels including in the corridors and in areas open to the	K0000	The creation and submission of this plan of correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation.This provider respectfully requests that the 2567 plan of correction be considered the letter of credible allegation and requests a desk review on or after August 12, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 01 B. WING	08/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT ROAD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	corridors. The facility has battery operated smoke detectors in all resident sleeping rooms. The facility has a capacity of 116 and had a census of 56 at the time of this visit. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 08/05/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0021 SS=E	Any door in an exit passageway, stairway enclosure, horizontal exit, smoke barrier or hazardous area enclosure is held open only by devices arranged to automatically close all such doors by zone or throughout the facility upon activation of: a) the required manual fire alarm system; b) local smoke detectors designed to detect smoke passing through the opening or a required smoke detection system; and c) the automatic sprinkler system, if installed. 19.2.2.2.6, 7.2.1.8.2 Based on observation and interview, the facility failed to ensure 1 of 1 rolling fire doors in the opening between the kitchen and the Dining Room is held open only by a device arranged to automatically close	K0021	K 0021 1. Rolling fire door has been inspected, serviced, and tested for proper operation as of 8/9/11.2. Residents in the vicinity of the Dining Room had the potential to be affected by this alleged deficient practice.3.	08/12/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 01 B. WING	08/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT ROAD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	upon activation of the fire alarm system. This deficient practice could affect any residents, staff and visitors in the vicinity of the Dining Room. Findings include: Based on observation with the Maintenance Supervisor and the Administrator during a tour of the facility from 10:15 a.m. to 12:30 p.m. on 08/02/11, the kitchen adjoins the Dining Room and a serving window from the adjoining kitchen is equipped with a rolling fire door. The Main Dining room was not separated from the corridor by positive latching entry doors. The serving window rolling fire did not self close upon activation of the fire alarm system at 11:51 a.m. on 08/02/11. Based on interview at the time of observation, the Maintenance Supervisor acknowledged the first floor Main Dining room is not separated from the corridor and the rolling fire door which was installed during the past year did not close automatically upon activation of the fire alarm system. 3.1-19(b)		Rolling fire doors will be inspected and certified yearly for proper operation to automatically close upon activation of the fire alarm system.4. The rolling fire door will be tested during the monthly fire alarm drill and the results of the fire door closing will be noted on the monthly fire drill report. A monthly audit will be conducted for 3 months to ensure rolling fire doors operate properly upon activation of the fire alarm system. Results of audits will be taken to facility monthly CQI meeting for review.Maintenance director is responsible. Completion date 8/9/11	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 01 B. WING	08/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT ROAD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 1 of 6 doors serving hazardous areas such as storage rooms greater than fifty square feet in size and used to store combustible materials are equipped with a positive latching mechanism on the doors. This deficient practice could affect any resident, staff or visitor in the vicinity of the Central Bath by Room # 67. Findings include: Based on observation with the Maintenance Supervisor and the Administrator during a tour of the facility from 10:15 a.m. to 12:30 p.m. on 08/02/11, the Central Bath by Room # 67 measured 100 square feet in size and was being used to store mattresses and housekeeping supplies. The entry room door is equipped with a self closing device but the door was not equipped with	K0029	K 00291. Storage room door latch was installed on 8/5 and tested for proper operation. Doors serving hazardous areas were inspected with no issues noted.2. Resident rooms 52 through 67 had the potential to be affected by this alleged deficient practice.3. Doors serving hazardous areas will be inspected monthly for properly functioning positive latching mechanisms.4. Doors serving hazardous areas will be inspected monthly as part of the facility preventative maintenance program and findings will be recorded. Monthly audit will be conducted for 3 months to ensure doors serving hazardous areas positively latch. Results of audits will be taken to facility monthly CQI meeting for review. Any future areas being used for storage that are greater than 50 square feet will have a positive latching mechanism installed prior to being placed in service.5. Maintenance director is responsible. Completion date	08/12/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 01 B. WING	08/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT ROAD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	a positive latching mechanism in order for the door to latch into the door frame. Based on interview at the time of observation, the Maintenance Supervisor stated the Central Bath is now being used as a storage room and acknowledged the Central Bath was greater than fifty square feet in size and has an entry door which is not equipped with a positive latching mechanism. 3.1-19(b)		8/9/11	
K0064 SS=E	Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1. 19.3.5.6, NFPA 10 Based on observation and interview, the facility failed to ensure 2 of 24 portable fire extinguishers had pressure gauge readings in the acceptable range. NFPA 10, the Standard for Portable Fire Extinguishers, Chapter 4-3.2(g) requires the periodic monthly check shall ensure the pressure gauge reading is in the operable range. 4-3.3.1 requires any fire extinguisher with a deficiency in any condition listed in 4-3.2(c), (d), (e), (f) and (g) shall be subjected to applicable maintenance procedures. This deficient practice could affect any resident, staff or visitor in the vicinity of Room # 75 and the Conference Room.	K0064	K 00641. Both affected fire extinguishers were replaced with units that had acceptable pressure gauge readings. All other fire extinguishers were inspected with no other issues noted.2. Resident rooms 70-77 had the potential to be affected by this alleged deficient practice.3. All fire extinguishers will be inspected monthly for acceptable pressure gauge readings.4. Utilizing the facility preventative maintenance program, all fire extinguishers will be inspected monthly for acceptable pressure gauge readings. Monthly audit will be conducted for 3 months to ensure all fire extinguishers have acceptable pressure gauge readings. Results of audits will	08/12/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155149	A. BUILDING 01 B. WING	08/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARCOURT TERRACE NURSING AND REHABILITATION	8181 HARCOURT ROAD INDIANAPOLIS, IN46260

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Findings include: Based on observations with the Maintenance Supervisor and the Administrator during a tour of the facility from 10:15 a.m. to 12:30 p.m. on 08/02/11, the pressure gauge on the portable fire extinguisher in the corridor by Room # 75 and on the portable fire extinguisher in the corridor by the Conference Room showed each extinguisher was undercharged. The inspection tags on each portable fire extinguisher listed the most recent annual inspection was in April 2011 and the most recent monthly inspection was 07/16/11. Based on interview at the time of observation, the Maintenance Supervisor stated staff recently used the portable fire extinguisher near the Conference Room to extinguish a brush fire outside the building and acknowledged each portable fire extinguisher pressure gauge indicated the fire extinguishers were undercharged. 3.1-19(b)		be taken to facility monthly CQI meeting for review.5. Maintenance director is responsible. Completion date 8/9/11	